Maryland Health Benefit Exchange Board Meeting

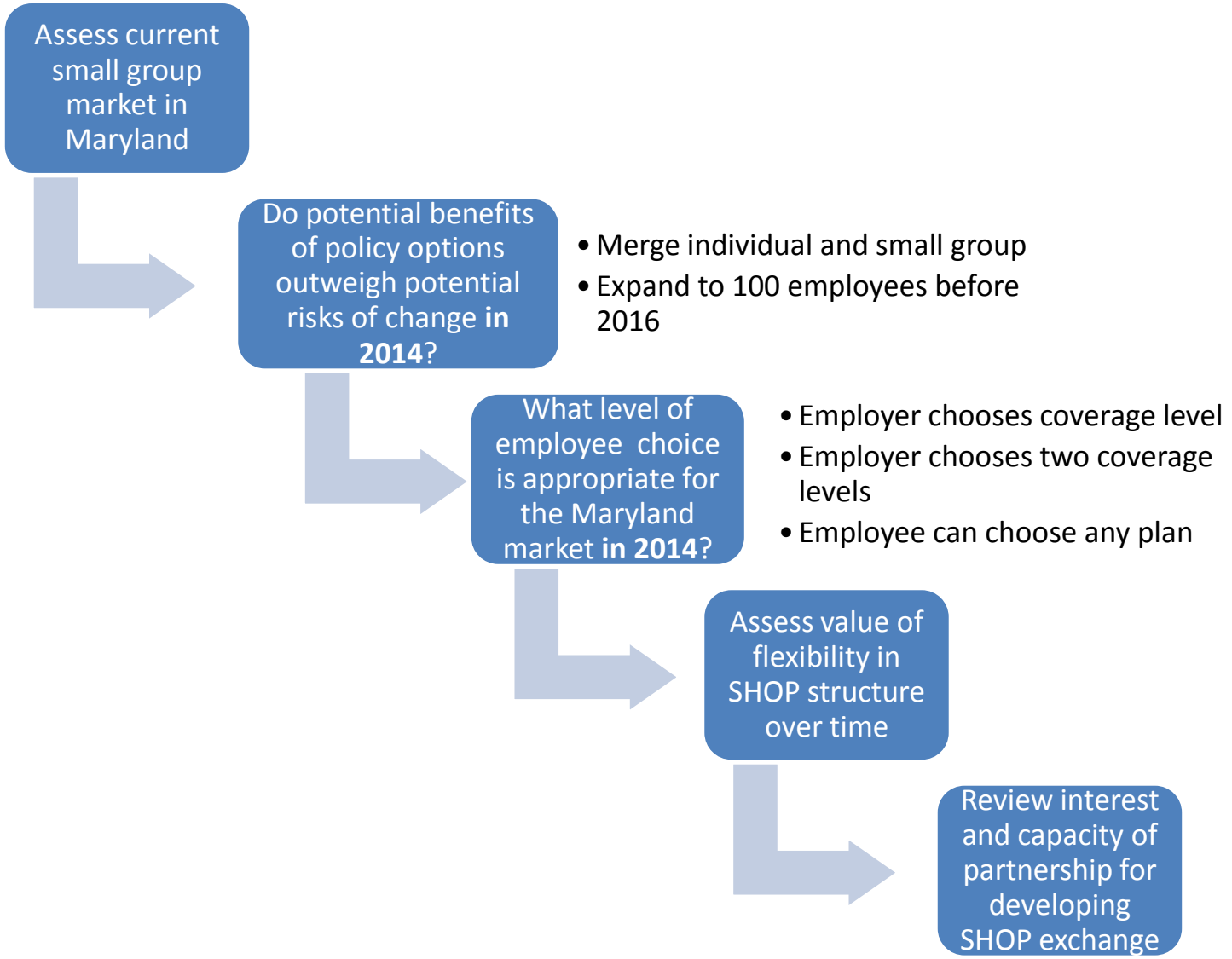
Discussion on SHOP, Dental, Financing, and Continuity

December 12, 2011

Agenda for Today's Meeting

- Pathway Discussions
  - SHOP
  - Dental
  - Financing
  - Continuity
- Next Steps

Pathway: SHOP



SHOP

Assess Current Small Group Market in Maryland

Market Assessment	Options
Covered Lives: • 365,000 individuals covered through 45,000 employers • 35-47% of small businesses offer coverage (IHPS, pg. 14) • 37% of small business employees in Maryland offered coverage accept it (IHPS, p. 14) • Proportion of groups offering coverage increases with employer size (IHPS, p. 14) • 34,000 individuals are covered through 19 association plans, which are governed outside of MD (Mercer MHCC Report, p. 23) • About 1% are self-funded with reinsurance at $10,000 specific/115% aggregate expected claims attachment points (GBS) ***Carrier Participation*** • 6 carriers participate in the small group market • 2 carriers account for 85% (CareFirst, United); Kaiser, Aetna, Coventry ,Graphic Arts make up rest ***TPA/Broker Relationships*** • At least 90% of small employers utilize a broker to purchase coverage • Majority of small group coverage in Maryland is administered through third party intermediaries – reported at 28,000 groups between 3 major TPAs • TPAs offer a full range of benefits and payroll services so small businesses, many of which do not have human resources departments, can reduce their benefit administration burden.(IHPS Technical Assistance p. 11)	N/A
Key Considerations N/A	**Recommendations** N/A

SHOP: Merging Markets

Do Potential Benefits Outweigh the Potential Risks in 2014?

Market Assessment

Individual Market Assessment

- 186,000 covered individuals
- 7 parent companies participate in the market
- Association plans cover at least 13% of the market
- Benefits are normally less comprehensive than group benefits because of adverse selection
- Plans must cover all MD mandated benefits
- Underwritten market – carriers can decline to cover based on medical history
- MHIP covers about 20,000 high-risk individuals
- Loss Ratio on MHIP members is over 300%

Options

Yes, benefits outweigh risks in 2014

1. Merge the Individual and Small Group Markets

No, risks too high in 2014

1. Do not merge markets
2. Delay decision until can measure impacts of reform

Key Considerations

Benefit: Larger Risk Pool/ Better Rates

- If the two markets are merged, whichever market has the lower average medical costs would have a greater rate impact as a result of the merger (IHPS, p. 10)
- ACA changes will have a 4-40% rate impact on the individual market (Mercer, p. 54)
- Mercer estimated 2-5% rate impact to small group (Mercer p.54).
- Both markets appear large enough that merging for critical mass may not be necessary (IHPS p.10)

Benefit: Stability

- If small group premiums rise as a result of merging, small groups might switch to self-insured or drop coverage (IHPS)
- 2014 will be unstable time in market
- Exchange needs to succeed with required functions in existing market

Risk: Barriers to Entry

- Some carriers do not currently operate in both markets. (Assurant, Healthmarkets, Graphic Arts)

Recommendation

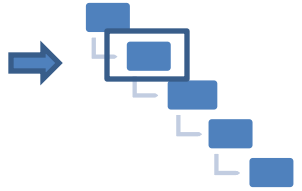
Do not merge.

Risks are too high in 2014.

Maintain flexibility to assess benefits once market stabilizes and make recommendation at future date.

SHOP: Expanding Small Group Market

Do Potential Benefits Outweigh Risks in 2014?



Market Assessment

- MEPS data indicate 117,858 private sector firms in MD:
  - 55.9% <10 employees, 11.9% 10 – 24 employees, 7.8% 25 – 99 employees
- 89% of 51-100 groups offer coverage (IHPS, p.15)
- 51-100 groups can be underwritten and experience-rated, and denied coverage
- 51-100 groups are more likely than small groups to self-insure

Key Considerations

Stability

- Changing definition in the Exchange changes definition outside Exchange.
- Uncertain if this provision will still be a requirement in 2016.
- 2014 will be unstable time in market – not sure how small groups will react to changes.
- Exchange needs to succeed with required functions within existing market.

Risk Pool

- Current small group is sufficiently large that expanding is not necessary to attain critical mass (IHPS, p.10)
- Self-insurance enables 51+ employers to enter/exit guaranteed risk pool as claims change
- Additional 2 years may give federal government chance to consider actions to limit self-insurance (IHPS, p.18)

Member Impact

- 51+ employers currently offer multiple plans within carriers and have option to offer more than one carrier
- Expansion could raise premiums for small group market (IHPS, p.20)

Options

Yes, benefits outweigh risks in 2014

1. Expand small group to 100 in 2014

No, risks too high in 2014

1. Defer expansion until 2016 when mandated

Recommendations

No. The potential benefits of expanding the small group market to include employers with 51-100 employees in 2014 do not outweigh the risks.

Do not expand the small group market until required to do so by federal mandate.

SHOP

What Level of Employee Choice is Appropriate in 2014?

Market Assessment

- ACA proposed regulations say SHOP must allow a qualified employer to select a level of coverage, where QHPs within that level are made available to all qualified employees of the employer (Proposed Regulations)

- In MD, small group employers can offer several plans from the same carrier, but not more than one carrier within an employer group

Key Considerations

The required SHOP design offers significant value to employers, employees, and the Exchange. The discussion should be focused on what additional choice, if any, should be offered.

Adverse Selection

- More choice relates to increased adverse selection
- Enabling free choice exacerbates this risk
- When carriers cannot adequately anticipate risk, additional costs are built into rates

Stability

- Small groups are used to offering one carrier with, if interested, several plan options
- When offered too many choices, consumers simplify the task in ways that do not conform to economist's model of a rational all-knowing consumer (IHPS, p.33)
- Exchange needs to succeed at implementing required elements

Administrative Burden

- Small businesses do not have HR departments to deal with payroll deductions and benefits
- Increasing employee choice could add administrative burden to small employer
- Employee choice disaggregates employer groups into individuals creating more burden on issuers, SHOP Exchange and employers to ensure billing and payment is correct
- SHOP will have to support additional functionality to make billing/payment easy for employer

Options (IHPS, p.22)

Options are representative of possibilities on a scale. This is not all-inclusive:

1. One issuer, any level
2. **One metal level, any QHP (ACA req't)**
3. Any metal level, any QHP

Recommendations

Use ACA-required level of choice in 2014.

Additionally -- allow groups to continue to offer one issuer with either one QHP or multiple QHPs within the Exchange.

SHOP

Assess Value of Flexibility in SHOP Structure Over Time

Market Assessment

- In 1994, when MD implemented health reform, there were 38 carriers offering coverage
- In 2006, 66% of small groups offered coverage to their employees
- In 2016, the Exchange is required to redefine the definition of small employer to include 51-100

Options

1. The Exchange should have the ability to modify the SHOP structure over time.
2. The Exchange should stick to the structure being recommended in 2012 for ongoing years.

Key Considerations

Market Changes

- Don't know how small employers will react to changes
- Tax credits are only available for 2 years creating a shift in the market as they disappear

Adverse Selection

- Will want the ability to assess the Exchange market to address any adverse risk issues

Sustainability

- Employees want choice.
- Choice enables individuals to choose based on other factors such as quality and price as opposed to what employer has chosen.
- Experience will enable Exchange to evaluate success of current model and potential for different models.

Recommendation

Yes, there is value in keeping the SHOP Exchange structure flexible over time.

The Exchange should re-evaluate the employee choice and individual/small group merger discussions in 2016 with recommendations for future.

SHOP

Review Interest and Capacity for Developing SHOP Exchange

Market Assessment

IHPS reviewed the capabilities of MD's three major TPAs as well as several National players.

All:

- Have an interest in supporting the SHOP Exchange
- Offer online plan comparison available for employers, employees, and brokers
- Support employee selection of plans defined by employer
- Use online and paper to enroll and dis-enroll employees and dependents
- Offer list billing
- Are audited by carriers for enrollment time limits, accuracy, and other factors

Most:

- Already support worker choice of competing plans for large groups
- Have customizable, adaptable, and flexible user interfaces for plan comparison
- Have systems that give permissions to multiple entities
- Host the software on their own servers using Microsoft-based technology
- Have quality standard requirements

Some:

- Have Research & Development teams and/or change control boards

Key Considerations

SHOP Operations

- Because of different enrollment, premium collection, and plan payment operations, separate systems are needed for SHOP and individual Exchanges (IHPS p.8)
- Because individuals may be going back and forth between the two Exchanges, close attention should be paid to interface and plan compare requirements.
- Potential volume of enrollment in SHOP Exchange requires partner(s) who can ensure success at high volumes
- Member choice requires SHOP to ease the administrative burden for employers
- Final requirements for plan comparison and SHOP have not been finalized

Options

N/A

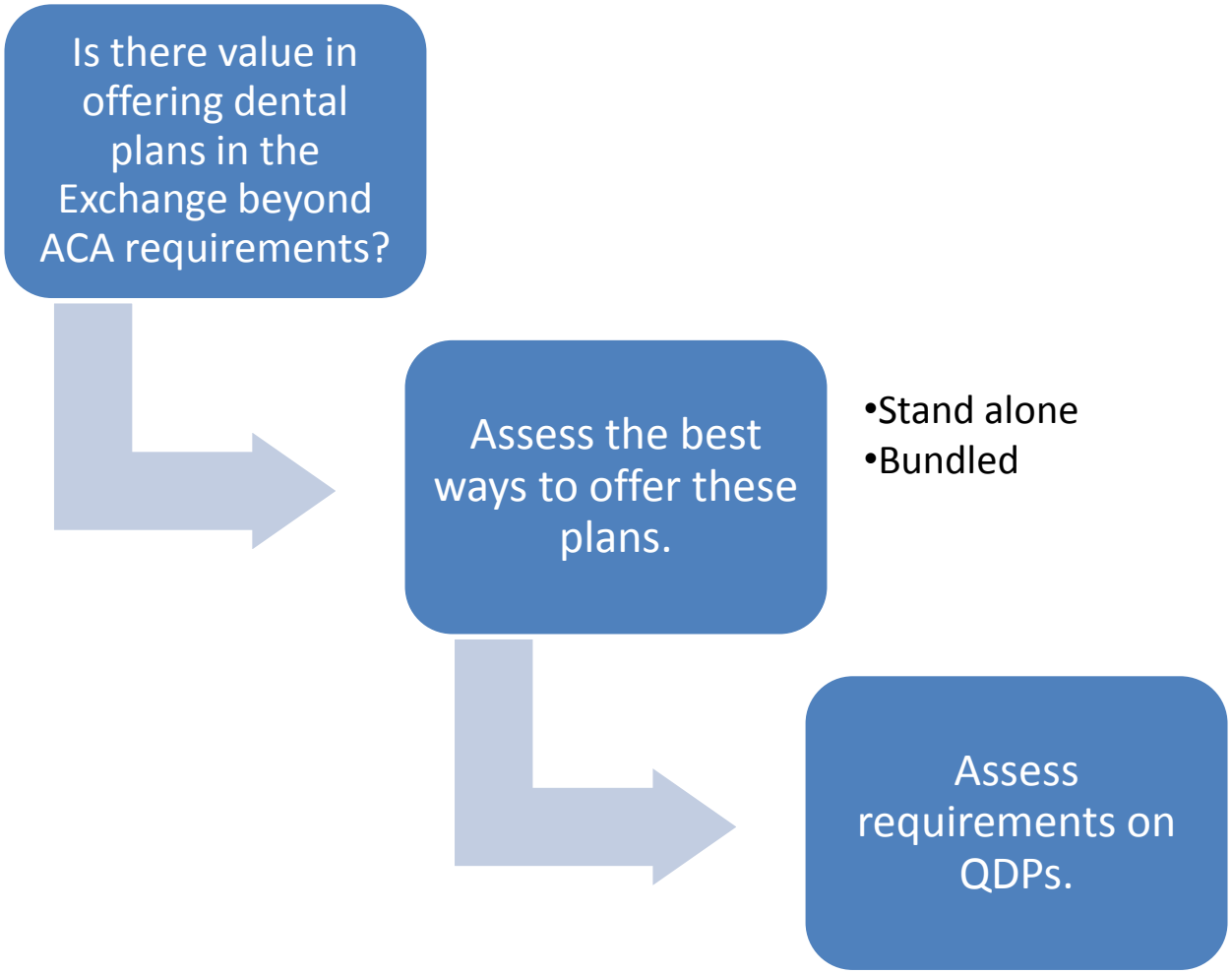
Recommendations

Based on analysis, there is interest, and the technical infrastructure and capacity to support SHOP Exchange look promising.

Exchange should do in-depth analysis as part of IT process to determine how best to move forward, taking into consideration technical requirements, continuity of plan compare experience and sustainability of the Exchange.

Plan should be finalized in early 2012 to meet implementation timelines.

Pathway: Dental Plans



Dental

Is There Value in Offering Dental Plans beyond ACA Requirements?

Market Assessment

- After medical, dental is rated as the next most important insurance benefit (AHIP)
- 80% of people with employer coverage have dental; 30% of individuals have coverage
- Majority of small companies in Maryland (<100 employees) who purchase dental coverage do so through stand-alone plans (Mercer p.31)
- In 2009, a stand-alone dental model was introduced in Medicaid which has greatly increased access (80% more providers) and utilization (up to 59%).

Key Considerations

Better Health

- Oral health is very important to overall health: signs and symptoms of disease, lifestyle behaviors, and exposure to toxins can be detected through the mouth; Oral infections can affect other areas of the body; associations between oral disease and chronic disease and adverse pregnancy outcomes (U.S. Surgeon General Report, 2000).
- Children whose parents visit the dentist are significantly more likely to have a dental visit than children whose parents do not visit the dentist (Isong et al, 2010)

Sustainability

- Consumers are used to purchasing dental and medical insurance together

Costs

- Because benefits would be optional, state would NOT have to cover additional costs of benefits

Support

- Advisory committee agreed and expressed concern about access to preventive dental care in Maryland
- Most committee members agreed that adult dental benefits should be offered at least as an option in the Exchange (Committee p. 11)

Options

1. Offer dental plans in the Exchange beyond the ACA Requirements
2. Do not offer dental plans in the Exchange beyond the ACA requirements

Recommendation

Yes, there is value in offering dental plans beyond ACA requirements.

Dental

Assess the Best Way to Offer These Plans

Market Assessment

- ACA allows stand alone dental plans to be offered in the Exchange
- 97% of U.S. commercial dental plans are stand-alone (Committee p.11)
- Maryland's Medicaid program recently carved dental services out of the MCO benefit package. They are now offered through a stand alone dental vendor.
- Over 30 carriers offer dental coverage in Maryland (Mercer p.32)
- Commercial medical plans offer dental as stand-alone products alongside medical.

Options

1. Offer dental through stand-alone dental plans
2. Offer dental through bundled plans that combine dental and medical benefits
3. Offer dental through both options.

Key Considerations

Health Equity

- Dental has unique challenges in terms of recruiting providers willing to treat vulnerable populations and the importance of preventive dental care is not always prioritized by insurance purchasers or multi-line carriers. Stand alone plans can address these issues (Committee p. 11).
- Bundled plans have resulted in network limitations and barriers to access in the past (Committee p.11).

Sustainability

- Individuals and groups have the ability to purchase dental benefits either through their medical carrier or through a stand-alone provider today.
- Bundled plans provide ease of selection for consumers (Committee p.11)

Support

- Committee suggested striking a balance between quality and access, and convenience and affordability

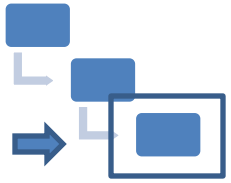
Recommendations

Offer dental as stand alone and bundled.

This ensures sustainability of the Exchange while addressing any possible health equity issues. It also increases competition which could keep rates low.

Dental

Assess Requirements on QDPs



Market Assessment

- ACA does not specify requirements for dental coverage beyond pediatric dental benefits. Each state has primary responsibility of identifying and administering the qualification requirements for dental plans within the Exchange (Mercer p. 32).

- Preliminary review of QHP requirements show only a few areas not applicable to QDPs:
  - Must cover EHBs and offer plans with actuarial values at one of four levels. Catastrophic allowed for young adults.
  - Participating carriers must offer at least one silver plan and one gold plan
  - Must comply with ACA risk adjustment program

Options

1. Follow QHP requirements
2. Use QHP requirements as starting point to define QDP requirements
3. Use other methods to define requirements

Key Considerations

Different Businesses

- State needs to consider differences in design and administration of dental and medical coverages (Mercer p.33)

Consumers

- Consumers should receive the same level of oversight and protection for dental plans that they do for medical plans
- Lax certification standards may result in a poorer consumer experience (Committee p.11)

Timing

- Dental plans need enough time to respond to requirements and be certified
- Exchange needs time to develop requirements, measurements and process for certifying plans

Recommendations

The Exchange should develop QDP requirements based on the QHP requirements at the same time QHP requirements are finalized.

Many of the currently outlined requirements on QHPs can apply to QDPs.

Pathway: Financing

Who benefits from the Exchange?

- People and carriers in exchange
- All insured and carriers
- Other entities in health care system: hospitals, clinics, etc.
- All Marylanders, even those not covered through the exchange

What financing options come to light based on above?

- People and carriers in exchange: surcharge
- Carriers inside and outside exchange: broader surcharge
- Other entities in health care system: share of reduced uncompensated care
- All Marylanders: tobacco tax, other assessments

Assess each relevant financing option

- Feasibility
- Stability
- Potential to distort market

Assess need for flexibility in financing mechanism

Financing

Who Benefits from the Exchange?

Market Assessment

- There are 730,000 uninsured in the state of MD
- Estimated 2014 enrollment in the Exchange without BHP is about 170,000

Key Considerations

Market Catalyst

- The Exchange is a distribution channel for carriers (Wakely p. 20).
- The Exchange benefits many stakeholders by:
  - Organizing the insurance market
  - Allowing people to more efficiently shop for insurance (whether through the Exchange or not)
  - Managing premium and cost sharing subsidies
  - Expanding insurance coverage (Wakely p. 20)
  - Educating consumers about health insurance

Costs

- As coverage increases, insurance premium revenue and hospital revenue will mostly likely rise and uncompensated hospital care will reduce (Wakely p. 24)
- Increased coverage may lead to improved population health, reducing cost over time (Committee p. 10)

Value

- Advisory Committee members agreed that the value of ACA and Exchange goes beyond the advantages of purchasing insurance through the Exchange (Committee p.10)

Options

The Exchange benefits: (continuum)

1. Carriers in Exchange
2. Carriers and individuals/groups in Exchange
3. Carriers and individuals/groups in Maryland
4. Everyone in insurance market
5. Everyone in Maryland

Recommendations

All Marylanders benefit from the Exchange, but with the Exchange acting as a distribution arm to insure more Marylanders and leading to a decrease in uncompensated care, the health industry benefits most.

Financing

What Financing Options Come to Light?

Market Assessment

Several MD agencies are funded through assessments:

- MHIP –hospital revenue
- MHCC – assesses hospitals, providers, carriers, nursing homes
- HSCRC – hospital revenue capped at $5.5M
- MIA – carriers' fully-insured business

Key Considerations

Stability/Reliability

- Board should consider whether given funding source is stable, reliable, and capable of mitigating the potential for revenue shortfall (Wakely, p. 3)
- Multiple funding sources increase the stability…contributing to sustainability (Committee Report p.10)
- The wider the net for assessments, the more stable the income

Narrow vs. Wide

- The wider the funding stream, the further you move away from a direct relationship to the Exchange
- Advisory Committee discussions focused on broad-based options

Impact on Market

- The wider the assessment, the lower the assessment rate by spreading the costs over a larger base
- Narrower the assessment could lead to higher barriers to entry

Options

Options range from narrow to broad-based.

QHP/Issuer Assessments

- Membership in Exchange
- All Membership
- All carriers in MD

Health Care Market Assessments

- Hospitals
- Providers
- Issuers
- Nursing Homes
- ASCs

Broad-based Assessments

- Tobacco tax

Repurpose Existing Revenue Stream

- Uncompensated Care
- MHIP
- Increased Insurance Premium Revenue

Alternative Sources

- Advertising
- Member assessments

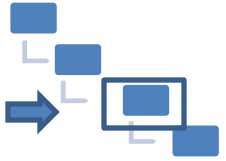
Combination of options

Recommendation

To ensure stability, a combination approach should be used.

Financing

Assess each Relevant Financing Option



Market Assessment

- Wakely estimates the overall cost of the Exchange to be (Non-BHP):
  - $24-30 million in 2014;
  - $38-$51 million in 2015
  - $44-61 million in 2016 (Wakely p. 2)
- Medicaid funding will be allocated based on shared functions

Key Considerations

Affordability

- Assessments cannot be excessive.

Sustainability

- Need to ensure proper cash flow

Costs/Revenue Requirements

- Variable based on enrollment
- ***Administrative Impact***
- Complex assessments may increase admin costs

Perception

- Recognition of Exchange's value to MD
- By MD statute, must be transparent

Legislature

- Legislature's decision on how to assess for funds.

Options

Same as previous.

Recommendation

Funding should begin with internal fees (Medicaid allocation, service fees) and supported by broader assessments. Assessments need to be capped to ensure affordability.

***Service Fees*:**

- **should be applied to issuers inside Exchange**
- **should be paid on all navigator-based enrollment**
- **should not exceed amount paid to brokers/TPAs outside Exchange**
- **should be alterable through Exchange regulations**

***Broad-based assessments on all carriers in market*:**

- **should be assessed to manage funding gap**
- **should be capped at 1% of overall premium for membership in/out Exchange**
- **should be based on budget needs for following year**
- **should be able to be assessed in emergency of cash-flow short-fall**

***Additional funding needs*:**

- **should be addressed through other broad channels**
- **could be addressed through licensing fees**
- **could be addressed through a tobacco tax**

Financing

Assess Need for Flexibility in Financing Mechanism

Market Assessment

Currently in a world of unknowns:

Unknown Market in early years of Exchange

- How many new and existing members will enter Exchange
- How many issuers will be in Exchange
- How the market will change after the first several years of enrollment

Unknown IT Requirements

- How complex the IT requirements with the federal government will be
  - Eligibility determination
  - Reporting to Treasury
- How requirements may change over time

Unknown Policy Decisions

- Whether MD will have a BHP

Unknown Impact of Required Future Changes

- How expansion of SHOP to 51-100 in 2016 will impact Exchange

Key Considerations

Flexibility to address variability and change:

- When choosing a financing option, the Board should consider if the financing method provides sufficient flexibility to support Exchange variability during the first few years of operation or in the event of low enrollment (Wakely p. 19-20).
- Any financing mechanism needs to be flexible enough to have the ability to adjust as the Exchange gets off the ground and as its enrollment mix changes over time. (Committee Report p. 6)

Options

1. Exchange does not need flexibility to address funding mechanism
2. Exchange needs flexibility to address funding mechanism in the future

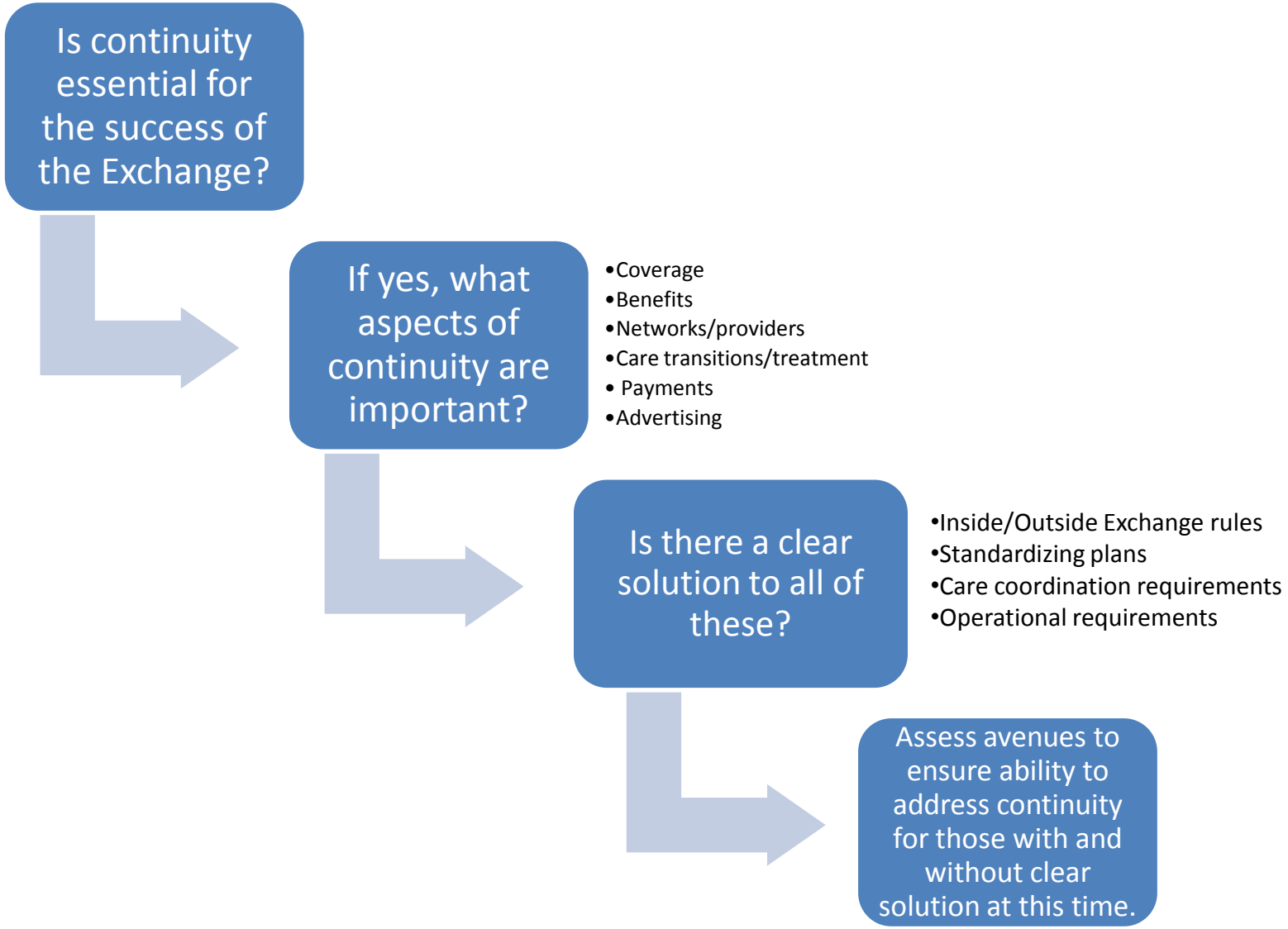
Recommendations

It is vital to review the funding mechanism to ensure funding is adequate and appropriate.

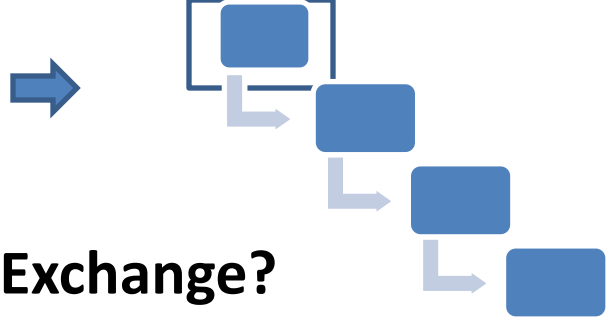
Annually, the Exchange will develop a budget, assess revenue needs and modify assessments.

Every two years, the Exchange should review funding mechanisms to ensure viability.

Pathway: Member Experience Continuity



Pathway: Continuity



Is continuity essential for the success of the Exchange?

Market Assessment

"Churn" will happen between Medicaid and the Individual Exchange, between Individual and SHOP, between SHOP and Medicaid, and between QHPs and non-QHPs

- National estimates suggest that 35% of adults with income below 200% FPL will transition between Medicaid and the Exchange in the first 6 months, 50% in the first year. (Sommers and Rosenbaum, 2011)
- Medicaid, MCHP and PAC all cover different individuals up to varying levels of FPL.
- Some small businesses that currently offer coverage may decide to drop it, especially if they have many modest-income workers who qualify for tax credits as individuals buying in the Exchange (IHPS, p.4)
- To prevent churn, states can make a priority of ensuring continuity of care between exchanges and Medicaid/CHIP (NGA)

Options

1. Address all places where members churning between entities may impact their experience.
2. Recognize where Exchange can affect change and focus on those.

Key Considerations

Sustainability

- Members dissatisfaction with health care in general will translate to dissatisfaction with Exchange.
- The greater the confusion, the higher the dissatisfaction.
- Viability of the Exchange depends on consumers willing to come back.
- Tax subsidies disappear in 2 years for small groups – leaving onus on Exchange to entice groups to continue to offer coverage through Exchange.

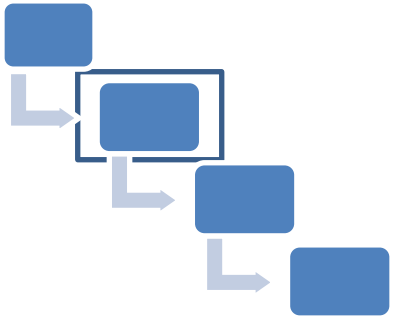
Costs

- Managing care transitions effectively lowers the overall cost of care.

Recommendations

Addressing specific pieces of continuity is essential for the success and sustainability of the Exchange but only where the Exchange can impact outcome.

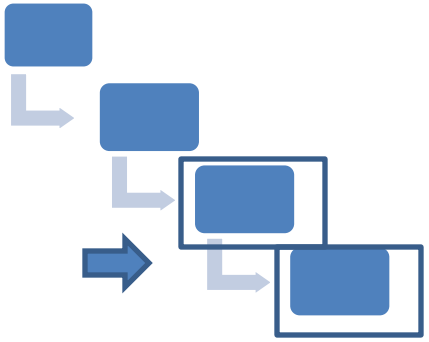
Continuity: Care Transition



If so, which aspects are important?

Market Assessment	**Options**
• NCQA requires transition of care standards for certain conditions. • CMS implemented a new policy this year to require a 90-day transition plan for individuals changing Part D plans. (Medicare Prescription Drug Benefit Manual, Chapter 6, Section 30.4) • HealthChoice regulations require Medicaid MCOs to pay for certain services without any requirement of referral by the PCP or MCO when the enrollee accesses the service through an out-of-network provider. • In general, enrollment brokers and providers are responsible for continuity of care during times of transition . • There is no language requiring care coordination between MCOs and Commercial carriers.	1. Care transition is important to the success of the Exchange. 2. Care transition continuity is not important enough to address – it's a fact of life.
Key Considerations	**Recommendations**
Care Costs • Requiring re-care to get prescriptions, continue services, etc. increases cost of care. ***Member Impacts*** • Care transition could be a great source of confusion and frustration -- which could be directed toward the Exchange. • Vital care could be put-off or postponed due to re-care requirements. ***Precedence*** • Current contracts in each environment require some sort of care transition.	**Ensuring care transition is essential to keeping costs down and satisfaction with the Exchange up.**

Continuity: Care Transition



Is There a Clear Avenue to Address?
Assess Avenues for Addressing in Exchange

Market Assessment	**Options**
• Same as previous	1. Rely on current transition of care clauses to support future transitions experienced between the Exchange, Medicaid and commercial market. 2. Require Medicaid MCOs and commercial carriers to have care transition clauses in contracts.
Key Considerations ***Inside/Outside Exchange*** • Individuals will also be moving between plans on and off the Exchange. ***Timing*** • Contracts would need to be updated to reflect coordination. • Carriers/MCOs would need to operationalize the care transition requirements. • Should be addressed as part of QHP certification process.	**Recommendations** **The Exchange should require transition of care language in contracts as a part of QHP certification, and work with Medicaid to require MCO contracts to require care transition.** **The Exchange should encourage the MIA review potential need for updates to commercial contracts to mirror QHP language.**

Next Steps

December 20 Meeting

- Outstanding items discussion
  - Navigator licensure
  - Process for EHB timing
  - Participation thresholds – In/Out
  - Fraud, Waste & Abuse
  - Multi-state or regional contracting

- Review Report

December 23

- Deliver Report